Exhibit D

The Diocese Of Greensburg

ELECTION TO WAIVE GROUP MEDICAL INSURANCE

(6)

If you decline enrollment in The Diocese of Greensburg Health and Welfare Benefits Plan's health coverage for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in the Plan's health coverage, provided that you request enrollment within 31 days after your other coverage or your dependent's other coverage ends. If you decline enrollment for yourself or your dependents because of other health insurance coverage, please provide details concerning your situation below in order to preserve your special enrollment rights in the future. In addition, if you have a new dependent as a result of marriage, birth, or placement for adoption, you may be able to enroll yourself and your dependents in the Plan's health coverage, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

EMPLOYEES WHO DECLINE HEALTH COVERAGE BECAUSE THE EMPLOYEE OR A DEPENDENT HAS OTHER HEALTH COVERAGE

If you decline health coverage under the Plan because of other health coverage for yourself or a dependent and you fail to provide the written statement concerning your (and/or your dependent's) other coverage or if you fail to request plan enrollment within 31 days after your (and/or your dependent's) other coverage ends, you will not be eligible to enroll yourself or your dependents(s), as applicable, until the next open enrollment period.

To Be Completed By Employee:

I understand that if I fail to complete the statement below or if I fail to request Plan enrollment within 30 days after my (or, as applicable, my dependent's) other coverage ends, I will not be eligible to enroll during a special enrollment period.

I am declining coverage at this time for the following person(s) for the following reason(s):

Person's Name, If Not the Employee, Relationship to Employee, and plan information if covered under another plan

Name: William D Fry

Relationship: Husband

- (●) Covered Under Spouse/Parent's Plan.
- ( ) Covered Under Another Employer's Plan as an Employee,
- ( ) Covered Under an Individual Policy
- ( ) OTHER:_____

Plan Name Highmark Comunity Blue Flex EPO

Member ID Number_____ Group ID_____

Plan Sponsor/Employer Hempfield Area School District

Name: Kenneth A. Ference Date: 9/2/2021

ELECTION TO WAIVE GROUP MEDICAL INSURANCE

I understand that I am eligible for benefits under the Diocese of Greensburg Health and Welfare Benefits Plan. I certify that benefits under such plan have been explained to me in detail. After careful consideration, I decline coverage and waive all claims to benefits under such plan. Because of my decision, I acknowledge and understand the following:

1. Re-enrollment into the above plan can only be done once yearly during the open enrollment period effective July 1st of each year *unless* I experience a *Life Change Event* as explained above.
2. **I HEREBY RELEASE AND HOLD HARMLESS** The Diocese of Greensburg **FROM** any and all **LIABILITIES** resulting from my decision to waive the group health insurance plan.

Name Kenneth A. Ference Date: 9/2/2021

5/2020